Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012939
STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 128 Primary Registration District No. 2002 Registrar's No. 379

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital — Length of stay in 1b: 20 days
d. STREET ADDRESS 0 (If outside, give location) — Reside on Farm Yes [ ] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Douglas
c. CITY OR TOWN Ava — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 0 3/10

3. NAME OF DECEASED (Type or print): First Middle Last — Bettie Jane Gardner

4. DATE OF DEATH: Month Day Year — Apr. 10, 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 17, 1876
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (City and state or country): [illegible] Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: James K. Long
13b. MOTHER'S MAIDEN NAME: Cydan Lundy
14. NAME OF HUSBAND OR WIFE: Albert Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mrs. Myrtal Robertson, Springfield Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident - left hemiparesis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Thrombosis of cerebral circulation
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart Disease 332X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED— WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-4-59 to 4-10-59 and last saw her/him alive on 4-10-59
Death occurred at 3:55 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Cecil R. Turner MD
22b. ADDRESS: 404 Professional Bldg Springfield, Mo
22c. DATE SIGNED: 4-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-13-59
23c. NAME OF CEMETERY OR CREMATORY: Murray
23d. LOCATION (City, town, or county) (State): Squires, Missouri

24. FUNERAL DIRECTOR ADDRESS: Clinkingbeard Funeral Home, Ava, Mo.
25. DATE RECD. BY LOCAL REG.: 4-15-59
26. REGISTRAR'S SIGNATURE: Effie G. Mellon

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Charles R. Fisk

Licensed Embalmer No 4662

P. O. Address Ava, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.